Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: TOMBALL REGIONAL HOSPITAL PO BOX 889 TOMBALL TX 77377	MFDR Tracking #: M4-06-0983-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: SECURITY NATIONAL INSURANCE CO Box #: 17	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "**We would like, at this time, to amend our original amount disputed to $3,164.44. The original calculations were done suing the ASC reimbursement methodology, when in fact, we area hospital and reimbursement should be calculated under the Hospital Outpatient Prospective Payment System, (HOPPS).**" "Additional reimbursement should be made because the carrier did not make 'fair and reasonable' reimbursement and did not make consistent reimbursements."

Requestor's Rationale for Increased Reimbursement from the Table of Disputed Services dated September 30, 2005: "ASC grp 3X213.3% Mltpl px dscnt pd 100%." "ASC grp 2X213.3% Mtpl px dscnt pd 50%." [sic]

Requestor's Rationale for Increased Reimbursement from the Table of Disputed Services dated October 20, 2005: "Market reimbursement of 140% of Medicare's Outpatient Prospective Pmt System (HOPPS) shall meet the statutory requirements of Section 413.011(d). Ingenix recommendation to the Dept of Wrkrs' Comp., then the Commission, in 2002 to develop MAR's for a hospital outpatient fee guideline. Multiple procedure discount is applicable-100" of primary px & secondary px reduced by 50%." [sic]

Principal Documentation:

1. DWC 60 Package
2. Medical Bill(s)
3. EOB(s)
4. Medical Records
5. Total Amount Sought - $463.48
6. Total Amount Sought per Amended *Table of Disputed Services* - $3,164.44

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "It is the position of the respondent that payment exception code 'M' is appropriate for this bill type since there is no outpatient fee schedule, payment is made at a fair and reasonable rate. The recommended payments reflect a fair, reasonable and consistent reimbursement pursuant to the criteria set forth in the Section 413.011(D) of the Act." "Charges for the facility in which the provider elected to have procedures performed on an outpatient basis are paid at a fair and reasonable amount per Section 413.011(b). Since expenses in an outpatient setting are reduced it is unreasonable to pay more for an outpatient procedure than an inpatient procedure. The established per diem rate for an inpatient surgical day is $1,118 and for a non-surgical day at $870. Using these two rates as anchor pints, reimbursement is based on the amount of time spent in the operating room." "The respondent respectfully submits that the amount of reimbursement was within the guidelines set forth in Section 413.011 and is consistent with earlier methodology used to determine payment."

Principal Documentation:

1. Response Package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
12/15/2004	M, (850-054), W10, W4, (920-002)	Outpatient Surgery HCPCS codes 29897 and 27695	$463.48	$0.00
			Total Due:	$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on September 30, 2005. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on October 10, 2005 to send additional documentation relevant to the fee dispute as set forth in the rule.

1. The requestor submitted their request for medical fee dispute resolution on September 30, 2005 and noted on the *Table of Disputed Services* a disputed amount of $468.43. Then, on October 20, 2005, the requestor submitted another *Table of Disputed Services* labeled 'AMMENDED' that listed the same HCPCS codes, but a different disputed amount of $3,164.44 with a different rationale noted above. The Division finds that per the August 29, 2005 letter, the requestor requested reconsideration for the disputed service based on the rationale listed on the *Table of Disputed Services* dated September 30, 2005**.** Therefore, the Division will consider the original *Table of Disputed Services* and disputed amount because that was what the respondent considered prior to the request for medical fee dispute resolution.

2. For the services involved in this dispute, the respondent reduced or denied payment with reason codes:
   - M-No MAR.
   - (850-054)-The recommended payments above reflect a fair, reasonable and consistent methodology or reimbursement pursuant to the criteria set forth in Section 413.011(D) of the Texas Workers' Compensation Act.
   - W10-No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
   - W4-No additional reimbursement allowed after review of appeal/reconsideration.
   - (920-002)-In response to a provider inquiry, we have re-analyzed this bill and arrived at the same recommended allowance.
3. This dispute relates to outpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. Division rule at 28 TAC §133.307(g)(3)(C)(iii), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "how the Texas Labor Code and commission [now the Division] rules, and fee guidelines, impact the disputed fee issues." Review of the submitted documentation finds that the requestor did not state how the Texas Labor Code and Division rules impact the disputed fee issues. The Division concludes that the requestor has not provided documentation sufficient to meet the requirements of Division rule at 28 TAC §133.307(g)(3)(C)(iii).
6. Division rule at 28 TAC §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the submitted documentation finds that the requestor did not state how the submitted documentation supports the requestor's position for each disputed fee issue. The Division concludes that the requestor has not provided documentation sufficient to meet the requirements of Division rule at 28 TAC §133.307(g)(3)(C)(iv).

7. Division rule at 28 TAC §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor's rationale for increased reimbursement from the *Table of Disputed Services* states that "ASC grp 3X213.3% Mltpl px dscnt pd 100%." "ASC grp 2X213.3% Mtpl px dscnt pd 50%." [sic]
   - The requestor seeks reimbursement based upon an ambulatory surgical care facility and they are a hospital facility.
   - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
   - The requestor does not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee charged for similar treatment of an injured individual of an equivalent standard of living, consider the increased security of payment, or otherwise satisfy the requirements of Texas Labor Code §413.011(d) or Division rule at 28 TAC §134.1.
   - The requestor does not explain how it determined that payment of the amount in dispute would result in a fair and reasonable reimbursement for the services in dispute.
   - The requestor did not submit convincing evidence to support the rationale for increased reimbursement.

   The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.
8. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code sections §133.307(g)(3)(C), and §133.307(g)(3)(D). The Division further concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311
28 Texas Administrative Code §133.307, §134.1
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature	Medical Fee Dispute Resolution Officer	**April 19, 2010** Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.